South Carolina Department of Disabilities and Special Needs

Report of Alleged Abuse, Neglect, or Exploitation

ADDENDUM TO: ☐ **Administrative Review** ☐ **Management Review** ☐ **Reinstatement Request**

Provide brief summarized information only in this report (additional sheets may be attached, if necessary)

This form should be submitted:

- when information on the Administrative Review or Management Review has changed or additional information needs to be provided after the review has been conducted,
- due to any change to the disposition of the case,
- when information pertaining to the results of outside agency investigations was received after the Administrative or Management Review was submitted
- to report the Provider's completion of recommendations made in writing by the Ombudsman's Office,
- due to changes regarding the status of employment/personnel action taken,
- in all instances where the Reinstatement Request has been approved or disapproved.

Provider Agency:

Name(s):	**1. Victim:**	**Perpetrator:**
	2. Victim:	**Perpetrator:**
	3. Victim:	**Perpetrator:**
	4. Victim:	**Perpetrator:**

Date of Incident:
If Date of Incident is unknown, indicate Date Incident Reported (also shown on Initial Report):

REASON FOR ADDENDUM

Brief explanation as to why Addendum is being submitted: ____

☐ Change in Final Disposition: ☐ Substantiated/Founded (Perpetrator Known) ☐ Substantiated/Founded (Perpetrator Unknown) ☐ Unsubstantiated/Unfounded ☐ Other Agency Investigating

☐ Change in Outcome: To: _____

☐ Reinstatement of Employee Indicate date employee returned to work:

☐ Employee Grievance ☐ Termination of Employee

☐ Employee Resigned or No Longer Works for Agency

☐ Result of Outside Investigation ☐ Result of Internal Review/Investigation

☐ Re-opened Investigation ☐ Result of Law Enforcement Investigation

☐ Other (Explain): _____

Indicate other investigative agency(ies) and that agency's Intake # or Case ID # where applicable :

Comments:

FINAL ACTION

SIGNATURE

_____

Executive Director/ CEO/ Facility Administrator (or Designee for Executive Director/ CEO/ Facility Administrator) *Date* Name of Person Completing Form

Send completed form within 24 hours or the next business day as a separate report (not to be included with Initial Report or Review) to:
Director of Quality Management, SCDDSN, PO Box 4706, Columbia, SC 29240, FAX # 803.898.7450

Form for Policy 534-02-DD; Form Effective 3/1/09